SENSE AND NONSENSE IN THE ARMY'S DRUG ABUSE PREVENTION EFFORT

by

LARRY H. INGRAHAM

As part of the effort to balance the federal budget, the Administration has proposed closing as many as 1000 drug abuse programs in the civilian sector.[1] Similar pressures within the military sector can be expected. If history is an indicator, slots will be eliminated and programs dismantled. After a predictable interval, there will be allegations that the Army is insensitive to drug use in its ranks, followed by publicity about the latest drug threat. These in turn will result in the hiring of new personnel and the creation of new drug abuse and prevention programs. Cycling every four to five years from drug crisis to drug crisis, the Army's drug abuse prevention program maintains itself, but at a price of cynicism on the part of those who have worked to establish credible programs and at a price of program credibility on the part of commanders who have responded to the cry of wolf too many times in the past. Perhaps there is a better way. The purpose of this paper is to suggest alternatives to the current Army drug abuse prevention program which are based on clinical and research experience over the past ten years.

WHAT IS THE PROBLEM?

Current policy falsely assumes consensus on the nature of "the drug abuse problem" in the Army. The rationale for current policy is not explicitly set down, but can be inferred from the basic regulation, AR 600-85, where drug *use* is essentially equated with drug *abuse*. It is instructive to note the definitional difference between alcohol and drug abuse. In the regulation, alcohol abuse is defined as "the *irresponsible use* of an alcoholic beverage which *leads to unacceptable social behavior or impairment of performance, health, or personal relationships with others.*" [italics supplied] "Other drug use" is defined as "the misuse of authorized medication or illegal use of any drug or chemical substance." In the case of alcohol, use must be irresponsible and lead to undesirable consequences. In the case of illegal drugs or chemicals, simple use, irresponsible or not, with or without undesirable consequences, is abuse. This definition, resulting from failure to define "the problem" carefully, confuses legal with moral issues, medical with behavioral issues, and leadership with control issues.

If the problem were seen solely as illegal activity, then a legal response would be all that is required. But the regulation also rests on the commonly held assumption that drug use, especially narcotics use, invariably leads to addiction and is impossible to treat successfully; therefore, it is assumed, drug use invariably results in deteriorating health, performance, and interpersonal relationships.

These assumptions seemed valid ten years ago, but they have not held up well in the ensuing years of clinical and research experience in managing drug use cases in the

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military. A careful study of soldiers detected with heroin traces in their urine upon leaving Vietnam revealed that casual use of heroin among soldiers was common, that use did not invariably lead to addiction, and that even when addiction occurred in Vietnam, usage did not continue once soldiers returned to the United States.[2] A recently completed study of drug overdose casualties among US Army troops in Europe revealed the same patterns.[3] Soldiers are apparently able to use heroin recreationally for up to two years without obvious signs of addiction or impairments to health and performance. These findings strike at the heart of national drug abuse policy as well as the Army drug abuse prevention program. Either the national policy is wrong, or soldiers are different from the general population. These findings are borne out statistically. In US Army, Europe, the estimate of monthly or more frequent users of hard drugs is 22,100 (13 percent of 170,000 junior enlisted); yet only 42 clients in the drug rehabilitation programs (1.8 percent of 2348 clients) are classified as addicted or seriously dependent.[4] The problem with drugs in the Army, then, is not addiction.

Neither is the problem one of individual health. In USAREUR, death by drug overdose is a statistically low .2 percent of the estimated 22,100 soldiers who use dangerous drugs monthly or more frequently.[5] There are, to be sure, trips to the emergency room and brief hospitalizations for treatment of acute drug overdose cases which are not monitored statistically. Further, hepatitis cases occasionally become sufficiently frequent to cause concern among both medical and line authorities, but the number of hepatitis cases does not correlate well with other estimates of drug use. Such stereotypical health consequences of drug use as rapid weight loss, irritability, constipation, and abscesses from needle use are uncommon in the population at risk in the Army, which is young, healthy, and in good physical condition.

Nor is the problem degraded performance, either in garrison or in combat, *when typical patterns of use exist*. Typically in the Army, drug use is recreational, episodic, and opportunistic, depending upon what is available at what price.[6] Drugs are usually employed after duty hours or on weekends in small enough doses that untoward effects on garrison military performance are difficult to detect.[7] Commanders are often confused on this point. They "know" drug use causes terrible soldiering since all of their terrible soldiers use drugs. But their inference is wrong. Most terrible soldiers use drugs, but not all drug users are terrible soldiers. In a recent study of drug overdose casualties in USAREUR, fully 75 percent of the victims were rated as good to outstanding soldiers.[8] Drug use is not necessarily incompatible with effective soldiership.

As for combat, there is no published report of heroin use interfering with combat performance in Vietnam. Soldiers are not fools. They know the dangers of working around heavy equipment or going into combat unable to function. Individuals who threaten the lives of others are oftentimes violently excluded from the combat group.[9] In Vietnam, during 1970-71, there were performance problems which resulted from heroin *withdrawal*, but not from heroin addiction per se. When users withdrew from heroin, they became sick with nausea, fever, aching joints, and running noses, not at all unlike mild cases of the flu.[10] Such soldiers could and did fight when required, but not optimally, to be sure. The distinction between combat performance while using heroin and

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Lieutenant Colonel Larry H. Ingraham holds a Ph.D. in social psychology from the University of Iowa. From 1970 to 1976 he was assigned to the department of military psychiatry at the Walter Reed Army Institute of Research in Washington, where his principal research interests were drug and alcohol use among soldiers in barracks. Since 1977 he has commanded the US Army Medical Research Unit (Europe) in Heidelberg, a special foreign activity of the Institute of Research. Research in the unit includes examinations of stress under continuous operations in artillery units, jet lag, drug overdose casualties, personnel attrition, cohesion, morale, and community life. The views expressed in this article are the author's and do not necessarily represent those of the US Army or Department of Defense.

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while withdrawing from heroin is not hair-splitting. Though, as we have seen, drug addiction is not extensive in today's Army, the problem it presents (to the extent that it presents a problem at all) lies in the potentially incapacitating effects of withdrawal and not in the use itself. We have fought and can fight again with addicted soldiers.

Problems, like beauty, lie in the eye of the beholder. Since the nature of the problem is obscure, it is little wonder that there is no consensus as to whose problem it is. Neither using nor non-using common soldiers accept illicit drug use as their problem.[11] Company-level leaders do not see drug use as an especially important problem for them, either. In order of importance, 250 USAREUR company and battalion commanders ranked illicit drug use as 26th of 39 issues that affect unit readiness.[12] Worldwide, 65 percent of commanders surveyed thought marijuana use had no effect on readiness; 80 percent said hard drug use would have no effect.[13] By default, then, "the problem" falls on others.

All of the foregoing is not to say that drug use cannot result in problems. Clearly in Vietnam during 1970-71, the symptoms of heroin withdrawal among soldiers became a problem by anyone's definition. This was followed in 1974-75 by an amphetamine epidemic in USAREUR marked by high rates of hepatitis. In both of these epidemics, significant numbers of soldiers were withdrawn from duty status and the medical system was taxed. Excepting these two episodes, however, drug use during the Seventies was not a significant Army problem with respect to addiction, health, or performance. Drug use poses a threat much in the same sense that venereal disease, food poisoning, and cold weather injuries are threats—they require constant vigilance, but not constant or exaggerated reactions.

CAN DRUG USE BE PREVENTED?

Current policy falsely assumes that drug use can be prevented by education. Even if public health education efforts were effective in general (and some deny that people can be reasoned, cajoled, or scared away from self-destructive behavior[14]), drug education efforts are doomed to be ineffective in the absence of a consensus on the place of drugs in American society. There are generational differences on what drugs are acceptable. Older Americans sanction alcohol and tranquilizers while younger Americans favor marijuana and other drugs. There are also differences within generations, with many younger Americans endorsing the use of all drugs save narcotics, while others find nothing shocking about narcotics use either. True, certain admonitory tags are seen frequently—"Do a friend a favor; turn him on to Life"; "Speed Kills"; or "Keep off the Grass"—but their bland and ambiguous nature belies a true consensus.

Current Army policy insists that drug education be factual and that it avoid scare tactics. However, as we have seen, the facts are in dispute, or at least not firmly established. Debate continues in political and scientific circles on the harm caused by smoking marijuana,[15] and the Army experience that narcotic addiction is not invariable or permanent has yet to dislodge conventional wisdom. It is difficult to educate soldiers about the dangers of use when the alleged "facts" are incongruent with the firsthand daily experience of users and the observations of many non-users.

Current policy falsely assumes urinalysis is a deterrent to drug use. There are logical and empirical reasons why this assumption is false. Logically, deterrence requires negative consequences upon detection: "Give me a clean urine, or else." But court rulings prohibit the use of urinalysis results as a basis of punitive action. The only consequence of a positive urinalysis test in the present system is referral to the drug treatment center, with the threat of discharge from service if rehabilitation fails. Drug counselors understandably resist the role of punitive agent, and many drug users do not view a discharge under honorable conditions as necessarily undesirable.[16] In many cases, the discharge is sought by soldiers who for one reason or another have become dissatisfied with the

conditions of their service, or is sought by commanders as part of a plea bargaining sequence in lieu of discharge for unsuitability or unfitness, which are more prejudicial.

In Vietnam, when return to the United States was contingent upon providing a clean urine sample, there was no evidence that the urine screen had any discernible effect on use.[17] If anything, the screen in Vietnam was more of an intelligence test. Those most likely to be caught were low-ranking volunteers who had little education, came from broken homes, had arrest histories previous to service, and had used drugs before entering the Army. In USAREUR, the "war on drugs" directed by the commander in 1978 included doubling the urinalysis rate. Were urinalysis a deterrent, the apprehension rate should have initially risen and then fallen as the word got out of the higher probability of detection. Nothing of the sort happened.[18] Not only did the number of urine positives fail to increase, but the estimated number of users remained unchanged.

We must conclude therefore that as a deterrent to drug use urinalysis is simply ineffective, though it is a useful surveillance tool, particularly for higher headquarters, and may be a useful detection tool if we can resolve the question of what to do with soldiers after they are caught.

WHAT HAPPENS UPON DETECTION?

Current policy falsely assumes that detected users will welcome and cooperate in attempts to treat, rehabilitate, or otherwise reform them. This assumption follows directly from the model of the frightened addict, in which treated and treaters are in agreement that a problem exists and something must be done. With respect to casual, recreational drug use, however, there is disagreement as to whether a problem even exists ("What's wrong with blowing a little grass or snorting a little skag?"). So far as addiction is concerned, experienced workers in the field are unanimous that intervention is effective only when the client has something important to gain if behavior does change, or, conversely, something important to lose if it does not.[19] For example, older service members have enough years in the Army that they have much to lose by being separated before retirement. Intervention in these cases, most often for alcohol abuse, is therefore quite promising. This situation does not pertain to younger soldiers, however, especially those who are seeking to avoid service contracts or who have been referred to treatment centers as a result of plea bargaining and feel they have more to gain by not changing than by changing.

Treatment goals are further obscured by the current policy assumption that drug use results from psychological defects which themselves can be treated and cured. While this assumption might be true in a few cases, the prevalence of illicit use among American youth is so widespread that simple use must be regarded as a group rather than an individual phenomenon. National Institute of Drug Abuse data in 1979 indicated that 65 percent of the nation's high school seniors reported illicit drug use at some time in their lives, and 37 percent of the class of 1979 reported use of an illicit drug other than marijuana at some time in their lives.[20]

Research within the Army suggests that drug and alcohol use in the military may be more a mark of social necessity than individual pathology.[21] That is, drug use in the barracks serves to bind soldiers together in the face of high personnel turnover and instability in social groups.[22] Drugs and the trappings of drug use—such things as music, dress, art, and jargon—provide minimally acquainted people with a ready and common basis for social interaction. Gossiping about the drug market, fads, fashions, and past experience with different substances plays an important role in creating and maintaining group identity. To the extent that the social implications of drugs are considered "bad," the counselor is left in the untenable position of having to choose between teaching the casual user how to survive as a social isolate and teaching him how to "do" drugs in the Army without getting caught.

All this implies that prevention and treatment, to the extent they are necessary, are to be sought at the group level rather than

the individual. The consequence of insisting that drug use is an individual rather than a group phenomenon is a tendency to limit the role of commanders to that of detection and elimination, and to absolve them of the broader responsibilities of monitoring and controlling drug use in their units.

IS THERE ANY HOPE?

Line commanders often plead for more realistic training and time in the field as "the cure" for drug use, which they attribute to boredom and the tedium of garrison routine. Though it is true that going to the field disrupts normal drug supply channels, and apparently does lessen drug use, such arguments ignore the fact that the worst drug epidemic experienced by the US Army happened neither in garrison nor in training, but in Vietnam while the Army performed its ultimate mission—war. To say that Vietnam was different, actually more like being in garrison than "real war," is silly. So long as American soldiers value drug-taking, the best prediction is that they will continue to use whatever is available at reasonable cost, whenever.

Another alternative is simply to continue muddling through with the same misguided albeit well-meaning policies in hope that we can stem the next major drug epidemic before the current program is dismantled in the next budget-tightening cycle.

A more rational middle course is possible, however. It is based on five principles derived from the past ten years of experience in managing drug abuse in the US Army:

► Though, as we have seen, drug use per se is not a serious threat to the health of the individual soldier or even to the performance of his own circumscribed duties, as a broader social phenomenon it *is* a threat to small-unit cohesion, good order, and discipline.[23] It threatens cohesion because it sets drug-using soldiers at odds with soldiers who prefer not to use drugs, but who must tolerate use in the barracks. It also sets the lower-ranking soldiers against the NCOs and officers who are charged with enforcing present policy. Drug use threatens discipline because it is illegal. Leaders cannot ignore violations of the law, no matter how difficult it is to enforce it. To wink at regulations or to enforce them selectively breeds cynicism toward all regulations, with ultimate dissolution of the bonds of discipline.

Drug use by groups reflects the frustrations, lack of power, and deficiencies of loyalty, trust, and commitment across the ranks. It sounds in the plaints of common soldiers—"You've got to get high or go crazy to make it in this unit"—which are counterpointed in the NCOs' defense of boozing it up—"What do you expect of us when all we have to work with are potheads and junkies?" The corrosion of faith is evident in commanders after the surprise loss of one of their best soldiers as a drug overdose victim: "You can't trust any of them." The sense of betrayal is obvious in first sergeants who say: "Today I can assure you there is only one person in this unit who is not on drugs—me!" The betrayal is reciprocated by good soldiers who are separated for reasons of drug abuse: "I was doing fine until I came up positive on the piss test; then they turned against me. I couldn't do anything right. They're prejudiced against drug users."

The divisive tension between "heads" and "juicers" did not end with Vietnam; it lurks in the shadows still and could reveal itself again as the former group disputes the other's right to say the time has come to go and die.[24] The last time there was a difference of opinion on this matter, Charlie company refused to move out, someone rolled a grenade under the first sergeant's bunk, and groups of soldiers withdrew from combat to hide behind the skirts of the medical tent with a diagnosis of drug abuse—the psychological equivalent of a self-inflicted wound.[25] Raising the specter of an addicted soldier with an M16 scares only little children in the dark. But raising the specter of the Army's cohesion again dissolving under the stress of combat sends chills through all thoughtful defense observers. That is the real threat, the real problem.

► The seriousness of the drug-use

threat to individual health and unit readiness depends upon what drugs are used, how they are used, with what frequency, and in what combinations. Because of its addictive potential, heroin poses a greater threat than does marijuana. Amphetamines injected by needle impose a greater threat than amphetamines taken orally because of the danger of hepatitis in needle use. The nature of the threat must be understood clearly before any special counters can be undertaken.

► It is important to set realistic goals. Drug use is endemic in American society and thus in the American Army. It can be monitored and to some extent controlled, but it cannot be eliminated.[26]

► In tactical units, drug users aggregate in company-sized pockets.[27] Evidence in USAREUR shows there are "clean" companies in "dirty" areas and vice-versa.[28] It follows that the appropriate level of intervention is the company, or perhaps the platoon and squad, but not the individual user.

► If intervention must occur in the user group—squad, platoon, or company—it follows that the most effective intervention agents are company leaders, not the experts in drug treatment centers.

BEGIN WITH ALCOHOL

A rational alternative to current policy would emphasize credible, decentralized *unit-level* alcohol abuse prevention programs; these are essential before any progress with other drugs can be expected. This is so for two reasons. First, alcohol abuse remains the most pervasive drug abuse problem in the American military.[29] Second, consistency of definitions and policies across the complete spectrum of alcohol, soft-, and hard-drug use and abuse is essential for credibility. All are familiar with the argument of younger soldiers, "Why are you coming down on me for using drugs when no one does anything about the alcoholics in the senior ranks?" True, this is a red herring. Studies show that younger enlisted people use prodigious amounts of alcohol as well as other drugs.[30] However, in order for any substance abuse program to be successful, it must be credible and equitable to all.

A credible company-level alcohol abuse program begins at the next higher level—the battalion. Battalion commanders serious about controlling abuse must ascertain who their alcoholics are. They should set as one of their performance goals that of having at least one alcohol abuser identified, treated, and returned to duty within the battalion each year. Further, battalion commanders need to take the risk of establishing unit lounges or clubs where alcohol can be served "at home," and where unit drinking standards can be established, monitored, and enforced by unit members taking care of their own.

Company commanders might reasonably seek to identify at least one active Alcoholics Anonymous member in the company to provide an informal resource for others who would like to discuss their own drinking habits, or who might need someone to lean on during their recovery process. AA members provide living proof that recovery from alcoholism is not incompatible with remaining in service.

Battalion and company commanders also need to set and enforce standards with respect to unacceptable behavior while under the influence of alcohol. Commanders who are serious should let it be known that such offenses as driving while intoxicated, drinking on duty, appearing for duty while intoxicated, and abusing family members while under the influence of alcohol (or while sober, for that matter) will meet with the maximum allowable punishment. Unit standards must include the requirement for mutual policing of members' behavior and reciprocal caring for drunk members.

Just as standards should be set regarding unacceptable drinking behavior, a definition of acceptable drinking behavior should be set before the troops. Standards include how much of which kinds of alcohol are permitted in the barracks. Through indoctrination and example, soldiers should be brought to realize that the appropriateness of drinking, like any other behavior, is dependent upon time, place, and circumstance. Drinking patterns at

a commander's formal reception, for example, are quite different from those at a beer bust when the unit returns from the field.

A credible unit-level alcohol control program should stress social activities in which significant drinking is less tempting or appropriate, for example, functions planned so that it is unnecessary to "kill the keg," an ample supply of non-alcoholic beverages is available, and family members are included. The inclusion of families serves two purposes. It discourages extreme drinking behavior with fewer fall-down-and-crawl-out consequences, while the inclusion of women and children increases the web of cohesion-building acquaintances and common interests within the unit.

MONITORING AND RESPONDING TO ROUTINE DRUG USE

A rational alternative to the present policy would be based on the public health model of monitoring critical indicators of drug use. Though current means do not permit greater precision than to say that drug use is up, down, or steady, multiple indicators can be tapped upon which to base this conclusion. These critical indicators for the company commander include sale and trafficking statistics in the area, informant intelligence, and questionnaire data on drug prevalence broken out by tactical units. Recent data from USAREUR indicate that drug offenses are highly correlated with other types of crime; therefore, monitoring Provost Marshal statistics is important as well.[31] Other sources of data a commander might use include emergency room reports of overdose cases and dispensary reports of needle use within the unit. Medics at unit dispensaries have a preventive medicine function as well as a treatment function. It is their responsibility to inform the commander whether needle use is up, down, or steady in the unit in the same way that they are supposed to advise on preventing cold weather injuries. A concerned commander should also monitor drug paraphernalia discovered during walk-through inspections of the barracks, and continue to rely on directed urinalyses of individuals suspected of hard drug use. None of the indicators is perfectly reliable, but taken together they permit a commander to judge whether drug use is increasing, decreasing, or stable within the unit.

Proper responses to endemic, routine, day-to-day drug use fall into three categories. The first is a refusal to permit an atmosphere conducive to or tolerant of illegal activities within the unit. Commanders have little control of actual use of illegal drugs, but can control evidence of such use. Frequent health and welfare inspections by squad and platoon leaders are essential and should be conducted without much concern for gaining prosecutions. The purposes of health and welfare inspections are to get the china back in the dining hall, tools back in the motor pool, moldy food out of wall lockers, and drug paraphernalia out of the area. Commanders also need to be certain that entire groups are made responsible for common areas. The discovery of contraband or paraphernalia in common areas will result in better housekeeping habits on the part of those responsible for that area, possibly through instruction on Saturday afternoon under the supervision of the group NCO.

The second category of responses to endemic use is a responsive, responsible medical system at the unit level to insure that no soldier dies from drug or alcohol overdose. Cases of drug overdose casualties in Europe indicate that the victims might often have been saved had there been first aid available.[32] On a unit level, this means putting priority on buddy aid in the barracks, to include cardiopulmonary resuscitation techniques. One difficulty in teaching first aid is building motivation. The greater immediate likelihood of a buddy dying from a drug overdose than from a combat wound should be exploited.

In addition, soldiers must be taught that they are responsible for each other's health and welfare. Under current policy, soldiers are faced with the unattractive choice of coming to a fellow user's aid, thereby possibly implicating themselves in drug use, or ignoring their buddy's plight. It must be

made clear that the greater offense is permitting another's death, not using drugs. Study of drug overdose casualties in Europe reveals many cases where soldiers were put to bed under the assumption (often correct) that they were drunk. Later, the victim vomited, choked, and died. The commander serious about providing responsive, responsible medical treatment in the unit would make it a matter of SOP that individuals unconscious for *any* reason would not be left unattended. It would then be CQ, unit medic, or buddy responsibility to monitor the victim until danger passed. Failure to discharge this responsibility would entail punishment for dereliction of duty.

Another counter at the unit level to drug overdose is to distribute narcotics antagonists to unit medics for use in emergencies in the barracks. Narcotics antagonists—drugs such as Nalaxone which combat the effects of overdose and reverse coma—have the ability to save lives when properly administered, do little harm when given inappropriately, and provide no "high" themselves. It behooves us to change medical policy so that narcotics antagonists can be routinely distributed among unit aidmen in the interest of saving lives.

A third response to endemic use is to concentrate directly upon enhancing unit cohesion, thereby improving communication among ranks and broadening group norms, again across ranks. Such norms would, of course, include acceptable drug and alcohol standards. Cohesion can be improved by all-ranks after-duty activities, all-ranks unit athletic programs, all-ranks unit dining, and a carefully designed welcome and orientation program. Casual individual drug use patterns cannot change significantly until group social patterns change. An appropriate role for the unit drug and alcohol education specialist would be the monitoring of informal social groups in the unit, the provision of alternative outlets in the form of athletics and recreation programs, and the conduct of the unit welcome and orientation program for newcomers. Obviously, regardless of its effect on drug use, the improvement of unit cohesion is desirable in and of itself, paying great dividends in terms of garrison, training, and combat performance.[33]

WHEN SHOULD A COMMANDER BE WORRIED?

The shift from endemic, casual use to seriously mission-threatening levels can be precipitous, depending upon what drugs are available, at what price, and current unit personnel traits. Commanders who tolerate flagrant evidence of drug use in their units are simply asking for trouble, though a commander should begin to get worried when there is *any* evidence of contraband or paraphernalia in the unit. The presence of such evidence indicates that the commander has been insufficiently concerned about the health and welfare of the unit. While drug use may be a fact of life in the Army, flaunting such use in the face of the commander undermines respect for and confidence in the unit's leadership; it is therefore intolerable and inexcusable.

The commander also should be worried when there are indications of marked adverse changes in patterns of use. These could include changes in drug preferences to narcotics, changes in ingestion patterns such as increased needle use, abrupt increases in unit crime, and more frequent referrals to the emergency room for drug-related treatment.

Finally, commanders must be concerned about *unit* performance and esprit. In the absence of documentary evidence to the contrary, it is best to go with folk wisdom: "Show me a unit where morale is low, maintenance is poor, and training is confused or nonexistent, and I'll show you a unit that is high in drug use."

As a rule of thumb, a commander needs to do something different when any of the indicators doubles in magnitude. "Something different" starts with a JAG seminar for unit leaders regarding search and seizure procedures and the rules of evidence. This is followed by stepped up monitoring and control activities; more frequent and rigorous health and welfare inspections; inspections conducted explicitly for drugs, including the use of drug-detecting dogs, unit urinalyses,

and breath analyses (for alcohol) of all unit personnel; and requests for surveillance of the unit by the military police criminal investigation division. The concerned commander should also request a consultation with an Organizational Effectiveness officer to explore the possibility that increased drug use is a signal of ineffective communications within the unit. Finally, the commander should consult a drug and alcohol counselor to gain assistance in defining the nature and extent of the drug threat to the unit.

AFTER YOU CATCH THEM

Commanders must recognize two categories of users—the casual, recreational users on one hand, and the chronic, dysfunctional users on the other. Casual, recreational use is principally a control issue. Legal recourse with formal punishment is appropriate whenever feasible. The object of such a policy—which is in fact the present policy—is to drive up the cost of casual use. When legal recourse is not feasible, increased individual or group training is in order, preferably on weekends or after normal duty hours, and preferably under the supervision of unit NCOs.[34] Intensified training as a response to detection of illegal drug activity is a constructive signal that unit leaders will not, by winking at offenses, serve as accessories before the fact. True, there is no evidence that any strategy has much success in "curing" casual, recreational drug use, but 3000 pushups a month under the direction of the first sergeant, or long marches on weekends, serve better to enhance military proficiency than dispatching the individual from the unit to a drug treatment facility. In cases where there is evidence of drug use in common areas in the barracks or work place, increased group training (no higher than squads or sections) is in order. For soldiers to survive in battle, they must be responsible for each other. If they cannot evade the suspicions of their commander with respect to illicit drug use, they will probably not be much better at evading an enemy on the battlefield. More training is therefore in order under the direction of a unit NCO so as to distribute ownership of "the problem" to all members of the unit.

Another option commanders should employ—though they would need to be given the appropriate authority—is to enroll detected users in a half-way house program in which soldiers work in their units during the day and return to a rigorous military milieu at night. The evening program would resemble that of community correctional facilities, but with instruction drawn from adventure, Ranger, and Special Forces type training. Behavioral-control means do not exist to induce soldiers to give up casual drug use, but ways to train them to be better soldiers are well known, and should receive the primary emphasis.

In cases of chronic, dysfunctional drug use, involving either medically defined or self-admitted dependence, soldiers ought to be offered a choice: detoxification and a discharge under less-than-honorable conditions, or detoxification in a medical facility with return to duty. Beyond these two courses, no specific medical expertise is required in dealing with drug-dependent or drug-addicted individuals. Assistance may be required by the dysfunctional user in budgeting his money, paying off debts, meeting new associates, settling family problems, or finding new activities to fill time. However, a drug rehabilitation center is not required for such assistance.

A rational alternative to the present policy would be to pare the present Community Drug and Alcohol Assistance Center down to the clinical director and a senior NCO counselor. The clinical directors—who currently approach drug problems as medical, individual problems—would instead spend full time advising commanders and unit drug education specialists on managing drug and alcohol problems in their units. The role of the NCO counselor would be to concentrate on maintaining contact with dysfunctional drug users—whether they are still with the unit or undergoing detoxification—advising them on resources in the community, assisting in solving personal problems, and providing

temporary counseling and emotional support until more functional behavior patterns are established.

CONCLUSION

Current drug abuse prevention policy is based on three false assumptions: that "the problem" of drugs in the Army is well understood and appropriately assigned, that prevention is possible, and that treatment is feasible. Rational alternatives to the policy based on these false assumptions are thus the order of the day. Would alternatives propounded in this article solve "the problem"? Certainly not in the eyes of those senior commanders who still insist on "zero defects." But these alternatives do represent entirely practical and reasonable approaches to the intractable human dilemmas posed by drug use. For commanders in the field who are concerned with drug use in their units, they offer a workable way to assure unit effectiveness and mission accomplishment while avoiding the pitfalls of cynicism and defeatism.

NOTES

1. See "Treatment, Prevention Programs Could Disappear Without Formula Fundings," *Washington Drug Review*, 5 (May 1980), 1.

2. L. N. Robbins, D. H. Davis, and D. N. Durco, "How Permanent Was Vietnam Drug Addiction?" *American Journal of Public Health Supplement*, 64 (December 1974), 38-43.

3. L. H. Ingraham and F. J. Manning, "Drug 'Overdose' Among US Soldiers in Europe, 1978-79: Psychological Autopsies Following Deaths and Near-Deaths" (paper, available from authors, has been submitted for publication).

4. T. S. MacDonough, "Program Evaluation Studies on 86 Treatment Programs for Substance Abusers in the US Army European Command from 1976 to 1979" (unpublished manuscript, Office of the Chief Surgeon, HQ 7th Medical Command, Heidelberg); see also "Substance Abuse in USAREUR," AEAGA-HRE letter [Human Resources Division, DCSPER, USAREUR], 22 March 1979.

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17. L. N. Robbins, "A Follow-Up of Vietnam Drug Users," Interim Final Report, Contract No. 45M-42-75, sponsored by Special Action Office for Drug Abuse Prevention (1973). Also see Ingraham, "'The Nam' and 'The World,'" op. cit.

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21. L. H. Ingraham, "The Need for Drug and Alcohol Programs that are Unique to Military Organizations," in *The Use and Abuse of Social Drugs*, ed. H. C. Holloway, Conference Proceedings No. 218 (Neuilly-sur-Seine, France: Advisory Group for Aerospace Research & Development, 1978). Also see F. J. Manning, "Cohesion and Readiness in USAREUR," *Air University Review* (forthcoming).

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26. It should be noted, however, that a recent service-wide survey conducted by the Department of Defense found that the incidence of hard-drug use among the services has decreased over the past five years. Based upon random samplings among almost 20,000 service men and women at 81 installations around the world, the survey found hashish and marijuana use about the same as in 1974, but a reduction in the heroin use rate from seven to two percent. One surprise finding was that senior NCOs are among the lighter drinkers among enlisted personnel, either in occasional use or in excess. See Richard Halloran, "Military Survey Finds Decline in Use of Hard Drugs," *The New York Times*, 8 December 1980, p. A19; and Paul Smith, "Survey Shows Extent of Drug, Alcohol Use," *Army Times*, 15 December 1980, pp. 4, 68.

27. Ingraham, "The Boys in the Barracks," op. cit.

28. M. Farmer, Chief of Evaluation Branch, Human Resources and Development, Deputy Chief of Staff for

Personnel, US Army Europe, personal communication, 23 July 1980.

29. Holsenbeck, "Drugs, Alcohol and Death," op. cit.

30. D. Cahalan, I. A. Cisin, G. L. Gardner, and G. C. Smith, "Drinking Practices and Problems in the US Army, 1972" (Arlington, Va.: Information Concepts, 1972).

31. M. Farmer, "Quarterly Alcohol and Drug Abuse Prevention and Control Program," briefing for Commander-in-Chief, US Army Europe, June 1979.

32. Manning and Ingraham, "The Face of Waste," op. cit.

33. F. J. Manning and R. Trotter, "Cohesion and Peacetime Performance by Selected Combat Units," VII Corps Commanders' Conference, Stuttgart, West Germany, April 1980.

34. We need no further medical or behavioral research on drug use in the Army, but we do need some legal research and policy refinement attuned to the requirements of commanders to maintain good order and discipline. This research should include sorting out how much of our current disciplinary procedure is grounded in public law, in Army administrative law, and in untested interpretations of both of these bodies of law. Assumptions defining the fine line between punishment and extra training need review, as well as those concerning group punishment.